



CALIFORNIA STATE ATHLETIC COMMISSION
1424 HOWE AVENUE, SUITE 33
SACRAMENTO, CA 95825
INTERNET: www.dca.ca.gov
(916) 263-2195 FAX (916) 263-2197



Professional Boxer/Mixed Martial Arts/Kickboxing Athlete

APPLICATION INSTRUCTIONS

You must submit the actual application form before or with your medical documents and other licensing materials. Medical documents will not be accepted without an application form on file in the office. The boxes on this instruction sheet must be marked indicating that all the documents and related information have been submitted before the application will be processed. If the checklist is incomplete, the application package will be returned.

1. **APPLICATION FORM** – Complete and sign. The Social Security Number is mandatory. Use your Social Security Number. It is a violation of federal law to use another person's SSN.

NOTE: The license will expire one year from the date the license is issued, i.e. a license issued on February 1, 2007 will expire on January 31, 2008.

2. **APPLICATION FEE** – \$60.00 Personal Check, Cashier's Check or Money Order enclosed.

3. **PHOTOGRAPH** – One recent passport sized photograph (2"x 2").

4. **NEUROLOGICAL EXAMINATION** – Must be performed and completed by a licensed physician that specializes in neurology or neurosurgery.

NOTE: For the 2007 licensing year, an examination dated on or after September 1, 2006 will be valid for the entire 2007 calendar year. Examinations taken on or after January 1, 2007 will be valid until December 31, 2007, unless the Commission orders additional medical testing.

5. **MRI (Brain Imaging Scan)** – Must be performed by an approved medical practitioner. (Baseline)

Please take this notice and the **MRI Review Summary** form to the neurologist or neurosurgeon that performed your neurological examination. Please have the report and form immediately faxed to the California State Athletic Commission at 916-263-2197.

As soon as possible, please arrange to have the images placed on a CD and forwarded to the Commission at: 1424 Howe Avenue, Suite 33, Sacramento, CA 95825. If a CD is not available, please forward the actual film within ten (10) days to avoid suspension of your license.

6. **EKG** – Must be performed by the licensed physician that performed your physical examination (Baseline). Please forward results with your license documentation.

7. **OPHTHALMOLOGICAL EXAMINATION** – Must be performed by an ophthalmologist and is valid for the one-year licensing period. The examination may be performed out of state

but a form approved by the Commission must be completed by the ophthalmologist. The examination must be completed at least 24 hours before the bout.

8. PHYSICAL EXAMINATION – Must be completed by a licensed physician. Valid for the one-year licensing period.

9. BLOOD TESTS RESULTS for HIV antibody & HBV Surface Antigen (Hepatitis B) & HCV (Hepatitis C) must be submitted with this application on the letterhead of the laboratory that administered the tests. The laboratory must be certified by the Federal Clinical Laboratory Improvement Act. The blood tests must be taken **within 30 days** prior to the date of application. Results for the 2007 licensing year must be dated no later than 30 days from the date the 2007 application is submitted to the Commission.

Example:

- Test results dated December 2, 2006 are valid for the next 30 days.
- Test results dated November 1, 2007 are valid for 180 continuous days.

Note: HIV, HBV & HCV tests must be retaken if the boxer or mixed martial arts athlete will be competing in a contest that will take place more than **180 days** from the date the initial tests were submitted for issuance or renewal of a license.

10. BOXER'S PENSION PLAN ENROLLMENT FORM – Enrollment in the Boxer's Pension Plan is voluntary and there is no fee; however, you must complete the enrollment form with beneficiary information in order to be entered into the program so that your rounds are calculated for eventual payment of retirement benefits.

BOXERS ONLY - Federal Identification (I.D.) Card

The Federal Boxing Act of 1997 requires every professional boxer to obtain a Federal I.D. card from his or her state of residence. If the boxer resides in a state or country where there is no boxing commission, the boxer must register in a state with a boxing commission. The boxer must appear in person at a Commission office and present a valid government issued photo identification with date of birth. Boxers must possess both the ID card and a valid license at the time of the weigh-in or he/she will not be allowed to compete.



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FREQUENTLY ASKED QUESTIONS

Q. What are some of the most important steps that I need to take to be assured that my suitability to compete will be properly and timely evaluated?

A. Do not rely on the advice of others. Read the application instructions and follow them without exception. Submit completed licensing documents in a timely manner. Call the Commission for assistance, if needed.

Q. What does the Commission consider as valid identification?

A. Any identification with a government issued photograph such as a passport, a driver license, verified immigration identification card, etc.

NOTE: Valid identification at the weigh-in is **mandatory**. If you do not provide a valid identification, you will not be allowed to compete.

Q. Why must I submit an application first? Why can't I turn in my medical reports and then turn in an application at the weigh-in?

A. The licensing process does not begin until the Commission receives a completed and signed application form. You may fax a copy to the Commission office to begin the process, but the original documents must be submitted at the weigh-in.

Q. Can I use medical reports from other states?

A. Out of state medical evaluations must be on Commission approved forms.

Q. How long is my MRI good for?

A. Another MRI will not be required unless you have suffered a pertinent untoward medical event. The first MRI will be used as a baseline.

Q. Do I have to take the MRI in California?

A. No. However, a Commission approved medical practitioner must administer it.

Q. Do I have to submit the actual MRI film with the report?

*A. In order to compete, you must submit the report and the **MRI Review Summary** form signed by the licensed physician specializing in neurology or neurosurgery who performed your neurological examination. A delay in receiving these documents may result in a cancellation of your bout. The Commission must receive the actual film no later than 10*

days from the date of the report. If you do not comply with this requirement, the Commission will suspend your license and notify the national registry of the suspension.

Q. Is there an age limit and if I am considered too old, what can I do to compete?

A. There is no age limit. Borderline or high-risk athletes will be required to undergo additional medical testing at the discretion of the Commission for obvious health and safety concerns. The Commission considers the following factors before it requires additional medical testing for athletes:

- Available information on www.fightfax.com and other internet sites such as www.boxrec.com, and various MMA web sites
- Opponents' records
- Licensure with another Commission
- Actual age
- Number of bouts
- Number of rounds fought
- Number of hard fights
- Number of identified injuries
- Number of knockouts suffered within the last 12 months where the contestant loss consciousness
- Periods of inactivity in excess of 12 calendar months
- Ring record for the past twenty-four months
- Weight, including fluctuations in weight
- Not meeting the vision requirements of Rule 282
- Previous cerebral hemorrhage or any other serious head injury
- Other physical disability that may affect the athlete's ability to compete safely

More importantly, passing medical testing does not guarantee that you will receive a license and/or be allowed to compete. **YOU MUST** demonstrate an ability to perform.

If you have any questions, you should contact the Commission **BEFORE** you undergo any medical testing for licensing.

Q. How long is my EKG good for?

A. The first test will be used as a baseline and you will not have to undergo another test unless you have suffered a pertinent untoward medical event.

Q. Why can't an optometrist perform my eye exam? Why does it have to be an ophthalmologist?

A. The Commission is evaluating the option of using an optometrist for eye examinations. At this time, the law only permits the Commission to accept eye examinations from licensed physicians.

Q. How long is my eye exam good for?

A. The eye exam is valid for each licensing year.

Q. Can I compete if I do not bring my federal I.D. to the weigh-in?

A. You will be fined but will be allowed to compete if you do not bring your federal I.D. to the weigh-in.

Q. Can I compete if my federal I.D. is expired?

A. Existing federal law has clear requirements. You can only renew your federal I.D. in the state where you reside. If your federal I.D. is expired, you will be fined and allowed to compete. However, you will be placed on suspension in the national registry until you submit proof that you have renewed your Federal I.D.

Q. How do I become licensed to make my pro debut?

A. First, contact the Commission. The Commission staff will evaluate any prior combative sport experience or lack thereof. Contact the Commission before you do anything.

Q. Can I compete if I am using prescription medication?

A. For health and safety reasons, the Commission may deny a license or refuse to allow you to compete if you are using medication that will enhance or diminish your performance, or medication deemed detrimental to your health and safety.

If you are on any type of prescription medication, including medicinal marijuana, you must disclose this at the time of licensing and/or as early in the bout approval process as possible. The Commission will require you to submit ALL pertinent medical information regarding the prescription medication for submission to a Commission physician for review. The review and approval process takes time; therefore, this information must be disclosed immediately in the event planning process.

If you do not disclose that you are taking a prescribed medication prior to the fight and your drug test is positive, you will be suspended, fined, and/or may be required to appear in front of the Commission. You may also be subject to other disciplinary action including denial or revocation of your license.

Q. Why does the Commission test for drugs?

A. The Commission is mandated to enforce Title 4. Business Regulations, Division 2. State Athletic Commission§ 303. Administration or use of drugs.

The rule states: The administration or use of any drugs, alcohol or stimulants, or injections in any part of the body, either before or during a match, to or by any boxer is prohibited.

Q. How do I know if I will be tested or not?

A. At events, all contestants are subject to drug testing. Contestants are selected in the following circumstances:

- *Championship bouts*
- *Main events*
- *Random selection*
- *Unusual circumstances*

Q. What kinds of substances may be tested for at an event?

A. The following is a list of substances for which the Commission tests:

- *Stimulants*
- *Narcotics*
- *Cannabinoids (Marijuana)*
- *Anabolic Agents (both Exogenous and Endogenous)*
- *Peptide Hormones*
- *Masking Agents*
- *Diuretics*
- *Glucocorticosteroids (Requires medical exemption)*
- *Beta-2 Agonists (Asthma Medications)*
- *Agents with Anti-Estrogenic Activity*

Q. Is it okay to use dietary supplements?

A. A wide range of products are considered dietary supplements including vitamins, minerals, amino acids, herbs, botanicals, and more. The Commission warns contestants that some of these products have a negative effect on performance.

Moreover, a recent International Olympic Committee (IOC) study found that 15% of the supplements tested were contaminated with steroids that would lead to a positive test. If a prohibited substance is detected in your sample – even if it was unintentional – it will result in a violation of Rule 303.

Q. What if I need to take medicine for my health?

A. Don't attempt to use a medical prescription as an excuse to circumvent the drug testing procedure or policy.

You must inform the Commission well before your bout if you are taking any kind of medicine. You will then need to be fully cleared by a Commission Physician. This may take time. Plan ahead. Many prescription and over-the-counter medicines can lead to a positive drug test, such as ADHD medicine, asthma inhalers, cold medicines, etc.

Call the USADA (Anti Doping Agency) Drug Reference Line (1-800-233-0393) to check any substance. You may apply to have medications containing prohibited substances approved for health conditions.

If you are taking a prescribed medicine, you must contact the Commission for instructions on how to apply for an exemption. This process needs to be completed well before the competition.

Q. What are my rights when I am being tested?

A. You have the right to:

- *Bring a representative with you during the test*
- *Have the Commission representative explain any procedure that you do not understand.*
- *Provide feedback. Please let us know if there is any way that we can improve our testing policies or procedures.*
- *Document any portion of the test that may not feel right to you.*

Q. Do I have any responsibilities regarding the drug test?

A. You have the responsibility to:

- *Comply with the doping control testing procedure. The procedures are set up to ensure that the sample you give is the sample that is analyzed.*
- *Report to the designated testing area as instructed by the Commission representative.*
- *Stay within view of the Commission representative from the time you are notified until the sample collection procedures are complete.*
- *Ensure that all paperwork is completely accurate.*

If a prohibited substance or method is detected in your sample – even if it was prescribed and the Commission was not informed in a timely and clear manner – it will result in a violation of Rule 303.

Q. Can I refuse to be tested?

A. A refusal is grounds for immediate indefinite suspension and withholding of pay. This means that you will be placed on the national registry as a suspended contestant and you will be ordered to appear in front of the Commission. You may also be subject to other penalties, such as license revocation and fine.

NOTE:

The Commission respects all contestants while at the same time striving to assure that they compete in a drug free environment. The Commission is always looking for better ways to improve the drug testing procedures and preserve the integrity of all contestants. This may result in changes to the collection process during calendar year 2007.



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APPLICATION FOR PROFESSIONAL ATHLETE

☐ **BOXING**
☐ **MIXED MARTIAL ARTS**
☐ **KICKBOXING**

**You must submit all the items listed below before your application is processed.
 Your application will be considered "Pending" if any information is not completed.**

- ☐ \$60 Application Fee.
- ☐ One (1) passport sized photograph (2"x 2").
- ☐ Neurological Examination Report (by licensed physician specializing in neurology and/or neurosurgery).
- ☐ Physical Examination Report by licensed physician.
- ☐ Ophthalmological Examination by licensed ophthalmologist.
- ☐ Negative HIV, HCV (Hepatitis C), and HBV Surface Antigen (Hepatitis B) test results must be submitted on the letterhead of a CLEA certified laboratory in the United States.
- ☐ EKG
- ☐ MRI

SECTION 1. Please Print the Following Information

 Social Security Number: **MANDATORY**

Last	First	Middle	
Ring Name:		() Area Code	Telephone Number

ADDRESS:

Street (No PO Box)	City	State	Zip Code	Country
Age	M / F	Birth Date: Mo ____ Day ____ Year ____	Height: ft. ____ In. ____	Weight ____ lbs

SECTION 2.

 Have you ever used any other name(s)? ☐ YES ☐ NO If yes, list name(s): _____

 Are you licensed as a professional boxer in any state or country? ☐ YES ☐ NO If yes, what country? _____

 Have you ever been disqualified in any contest? If "Yes", explain. ☐ YES ☐ NO

 Has your licensed ever been denied, suspended or revoked in any state or country for medical reasons? ☐ YES ☐ NO
 (DO NOT INCLUDE ANY ACTION BASED ON HIV/HBV TEST RESULTS) If "Yes", explain and list the state or country:

SECTION 3. AMATEUR BOXING RECORD:

WINS: _____ WINS BY KO: _____ LOSSES: _____ LOSSES BY KO: _____ DRAWS: _____

SECTION 4. PROFESSIONAL BOXING RECORD:

WINS: _____ WINS BY KO: _____ LOSSES: _____ LOSSES BY KO: _____ DRAWS: _____

SECTION 5. MARTIAL ARTS RECORD:

WINS: _____ WINS BY KO: _____ LOSSES: _____ LOSSES BY KO: _____ DRAWS: _____

SECTION 6.

If you are now or have ever been licensed by the California State Athletic Commission, another athletic commission, or any similar governmental authority, provide the following information for each license, listing the most recent first:.

Type of License	Year License was Issued	State or Other Commission/Government Authority
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your license ever been suspended, revoked or fined by the California State Athletic Commission, another athletic commission or any similar governmental authority? ☐ Yes ☐ No If YES, provide the following information:

TYPE OF LICENSE	ACTION TAKEN	REASON FOR ACTION	DATE OF ACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there charges pending against you by the California State Athletic Commission, another athletic commission or any similar governmental authority? ☐ Yes ☐ No If YES, provide the following information:

CHARGE	DATE OF CHARGE	GOVERNMENTAL AUTHORITY	HEARING DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been convicted of a crime in the past 10 years, regardless of adjudication? ☐ Yes ☐ No If YES, provide the following information:

CRIME	DATE OF CONVICTION	CITY, STATE, COUNTRY	SENTENCE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there any charges pending against you by any law enforcement agency? ☐ Yes ☐ No If yes, provide the following information:

CHARGE	DATE OF CHARGE	CITY, STATE, COUNTRY	TRIAL DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 7.

Do you have a certified managerial contract with any licensed Manager(s)? ☐ YES ☐ NO

If yes, list **ALL** name(s) of those who have a financial or proprietary interest in your ring earnings. Also list the state or country where the contract was certified.

SECTION 8. PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name _____ Relationship _____
Address _____ Phone Number _____
City _____ State _____ Zip Code _____ Country _____

PLEASE READ CAREFULLY

Authority to provide the California State Athletic Commission with this information is established pursuant to Sections 18640, 18642 and 18643 of the Business and Professions Code. Disclosure of your social security number is mandatory pursuant to Section 30 of the Business and Professions Code and Pub. L.94-455 (42 USCA 405 (c) (C) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code. The social security number is also used to report and credit boxer pension fund payments in implementing Sections 18880, 18881, 18882, 18883, 18884, 18887, and 18888 of the Business and Professions Code. If you fail to disclose your social security number your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Information on your application and physical examination report may be released to law enforcement agencies. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Executive Officer is the custodian of records.

CHILD SUPPORT INFORMATION

Please mark the appropriate response. Failure to do so shall result in the denial of your application and administrative suspension.

- ☐ I am not the subject of a child support court order.
- ☐ I am the subject of a child support court order.
- ☐ I am the subject of a child support court order of one or more children and I am in compliance with the order, or I am in compliance with the plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.
- ☐ I am a subject of a child support court order of one or more children and I am **not** in compliance with the order, or with the plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order

I declare under penalty of perjury under the laws of the State of California, that I have read the foregoing application for a professional athlete's license and that all the answers given are my own. I further declare that all the answers are true AND THAT THE HIV/HBV/HCV TEST REPORT REPRESENTS MY HIV/HBV/HCV TEST RESULTS. I understand that any misstatement of material fact in this application will constitute grounds for denying or revoking the license.

Applicant's signature: _____ Date: _____

This item is VOLUNTARY. You do not have to check this box.

[] I hereby authorize the California State Athletic Commission to release my telephone number to any commission licensee for contact purposes. This authorization shall be valid during the license year in which this application is signed.

OFFICE USE ONLY

License #: _____ Federal ID #: _____ Expires: _____

Amount Rec'd: _____ Method of Payment: _____ Receipt #: _____

P/E Date: _____ HIV Date: _____ HBV Date: _____ HCV Date: _____

Ophthalmologic _____ Neuro Exam Date: _____ EKG Date: _____ MRI Date: _____

Suspensions:

License Approved from _____ to _____

Authorized Signature _____ Date _____



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PROFESSIONAL ATHLETE PHYSICAL EXAMINATION

APPLICANT NAME	RING NAME	TELEPHONE	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP CODE COUNTRY

PHYSICAL HISTORY: Have you ever had any of the following conditions:
☐ Fainting spells ☐ Rupture (hernia) ☐ Chest pains ☐ Operations ☐ Shortness of breath ☐ Swollen joints
☐ Rheumatism ☐ Diabetes ☐ Frequent headaches
☐ Convulsions (fits) ☐ Chronic cough ☐ Spitting of blood
☐ Cerebral hemorrhage or serious head injury ☐ None
 No. of knockout losses in your career _____ Date of last knockout _____
 Have you ever suffered a loss of consciousness for any reason? ☐ YES ☐ NO
 If so, please explain and provide date(s) and location(s): _____

When was the last time you took any type of medication or drug? (State what type and when) _____

Have you ever undergone any type of surgery? ☐ Yes ☐ No If so, please describe. _____

When was the last time you took any type of vitamin supplement? (State what type and when) _____

Amateur record: Wins _____ Losses _____ Draws _____
 Professional boxing/martial arts record: Wins _____ Losses _____ Draws _____
 Additional information: _____

PHYSICAL EXAMINATION:
 General appearance: _____ Height: _____ Weight: _____ Temperature: _____
 Disabling scars: _____ Mouth: _____ Teeth: _____ Tonsils: _____ Neck: _____
 Pulse at rest: _____ Pulse after 100 hops: _____
 Blood pressure: At rest: _____ After 100 hops: _____ 2 minutes later: _____
 Enlarged glands: ☐ Yes ☐ No - Goiter: ☐ Yes ☐ No
 Heart: Pulse rhythm ☐ Regular ☐ Irregular - Murmurs: ☐ Yes ☐ No
 Apical impulse: ☐ Heavy ☐ Normal - Enlargement: ☐ Yes ☐ No
 Lungs: Rales ☐ Yes ☐ No - Abdomen: Enlargement of liver ☐ Yes ☐ No
 Breasts: Mass ☐ Yes ☐ No - Tenderness ☐ Yes ☐ No - Discharge ☐ Yes ☐ No
 Enlargement of Spleen: ☐ Yes ☐ No - Hernia: ☐ Yes ☐ No
 Femoral ☐ Inguinal ☐ Ventral - Testicles: Normal ☐ Yes ☐ No
 Remarks: _____
 Reflexes: Pupils _____ Knee jerks _____ Romberg _____
 Babinski _____ Skin: Tone _____ Rash _____ Boils _____ Other: _____
 Unhealed wounds: _____
 Remarks: _____

EYE HISTORY: Have you ever had any of the following conditions:Blurred vision? ☐ Yes ☐ No – If YES, please explain in full: _____

Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye?

☐ Yes ☐ No – If YES, please explain in full: _____
_____Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? ☐ Yes ☐ No – If YES, please explain in full:

_____**EYE EXAMINATION:**

Vision without glasses Right _____ Left _____

Vision with glasses Right _____ Left _____

Visual fields Right _____ Left _____

You must also go to an ophthalmologist for a dilated eye examination

EXAMINING PHYSICIAN:I have examined the above named applicant and I ☐ **DO NOT FIND** ☐ **DO FIND** a condition that would preclude him/her from being licensed as a professional ☐ boxer, ☐ kickboxer, or ☐ martial arts athlete.

The California State Athletic Commission is a health care oversight authority, as defined in 45 CFR 164.501, exempt from HIPAA, and is authorized by Business and Professions Code Section 18600, et seq to collect information about the applicant's physical condition. Authorization for release of medical information is attached.

LICENSED PHYSICIAN'S NAME (print)_____
MEDICAL LICENSE NUMBER_____
ADDRESS_____
CITY_____
STATE_____
ZIP CODE_____
TELEPHONE NUMBER_____
DATE/TIME_____
PHYSICIAN'S SIGNATURE**Office Use**

Approved By: _____

Date: _____



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ATHLETE OPHTHALMOLOGIC EXAM

Examinations will only be accepted if performed by a licensed physician/surgeon

First Middle Last Ring Name Telephone Date of Birth

Address City State Zip code Country

HISTORY – Please provide the following information:

Name and hometown of your primary care physician: _____

Has applicant ever had any of the following conditions:

1. Blurred vision? Yes No
2. Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye? Yes No
3. Has applicant had or been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract? Yes No If yes, please explain: _____
4. Eye Disease? Yes No List nature of diseases or injuries: _____
5. Eye Injury? Yes No List nature of diseases or injuries: _____
6. Retinal re-attachment? Yes No If yes, please explain: _____
7. Does the applicant have any other visual condition that would prevent him/her from safely engaging in boxing or martial arts activities? Yes No If yes, please explain: _____

EXAMINATION

VISION: Without / With Glasses

Right _____ / _____
 Left _____ / _____

REFRACTION: If either eye is 20/60 or worse:

Right _____ Sph _____ Cyl x _____ Acuity _____
 Left _____ Sph _____ Cyl x _____ Acuity _____

Remarks: _____

Intraocular Right _____ mmHg
 Tension Left _____ mmHg
 Motility Normal _____ Abnormal _____
 Binocular Vision Normal _____ Abnormal _____

SLIT LAMP EXAM

Conjunctiva

Cornea

Iris/Pupil

Lens

Eyelids

NORMAL

Right/Left

_____ / _____

_____ / _____

_____ / _____

_____ / _____

ABNORMAL

Right/Left

_____ / _____

_____ / _____

_____ / _____

_____ / _____

SPECIFY ABNORMALITIES

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

	NORMAL Right/Left	ABNORMAL Right/Left	ABNORMALITIES
Disc_____	____/____	____/____	_____
Macula_____	____/____	____/____	_____
Vessels_____	____/____	____/____	_____
Peripheral Retina_____	____/____	____/____	_____

PHYSICIAN'S REMARKS:

Title 4, Rules and Regulations, §282 states: The commission shall deny, suspend, revoke, or place restrictions on the license of a professional or amateur boxer or martial arts fighter because of a medical or visual condition, including but not limited to one of the following:

- 1) Uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes;
- 2) Corrected visual acuity of less than 20/60 in either eye, regardless of its cause;
- 3) A visual field of 60 degrees or less extending over one or more quadrants of the visual field;
- 4) Presence or history of retinal detachment or retinal tear unless treated by an ophthalmologist and then approved by an ophthalmologist specified by the commission who then assesses that the boxer is at no significant risk of further injury to the retina if boxing is resumed. Such assessment shall occur both within five days before and five days after the contest;
- 5) Presence of primary or secondary glaucoma, whether or not such condition has been treated;
- 6) Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye;
- 7) Any other visual condition which the commission determines would prevent the applicant or licensee from safely engaging in boxing activities.

Examining physician: Please mail a copy of any report, directly to the commission, for any applicant who has a condition that may preclude him/her from being licensed.

PHYSICIAN:

I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on the other side of this form.

I Do Not Do find any condition prohibited by Rule 282 and/or any other condition that would prevent the applicant from safely engaging in any boxing or martial arts activities as a professional boxer, or a martial arts athlete.

Physician's Name and License Number

Physician's Signature

Address

Date

City

State

Zip Code

Telephone Number

Authorization to Use and Disclose Protected Health Information

The California State Athletic Commission is a public health authority, as defined in 45 CFR 164.501, exempt from HIPAA, and is authorized by California Business and Professions Code Sections 18600 et seq. to collection information about the applicant's mental and physical health.

I hereby authorize my personal physicians and other healthcare providers and all hospitals or similar institutions or organizations to furnish to the California State Athletic Commission or its successors copies of all my medical records, hospital records, records of treatment for drug and/or alcohol abuse or dependency, or other information requested by that Commission in connection with this application or any further or future investigation by that Commission necessary to determine my fitness for licensure.

I further authorize the Commission or its successors to release any medical or other personal information with respect to my application or licensure to the organizations, individuals or groups listed above and to other regulatory bodies. The Commission will release this information only to those athletic commissions (or similar regulatory bodies) that have a need to know, as determined by the Commission. This disclosure of records is required for official use, including investigation of my fitness for licensure by the Commission. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to receive a copy of this authorization if I request it. I may inspect or obtain a copy of the protected health information that I am being asked to disclose.

I understand that I have a right to revoke this authorization by sending written notification to the California State Athletic Commission, 1424 Howe Avenue, Suite 33, Sacramento, California 95825. I understand that if I revoke this authorization, I may not be allowed to continue in the licensure process, or, if I am licensed, my license may be adversely affected.

This authorization shall remain valid for one year from the date a license is issued to me. A copy of this authorization shall be as valid as the original.

Name of Applicant

Date

Signature of Applicant



CALIFORNIA STATE ATHLETIC COMMISSION
 1424 HOWE AVE. STE. #33
 SACRAMENTO, CA 95825
 INTERNET: www.dca.ca.gov
 (916) 263-2195 FAX (916) 263-2197



NEUROLOGICAL EXAMINATION REPORT

(Must be administered by a licensed physician who specializes in neurology or neurosurgery)

Last Name	First Name	Date of Birth
Street Address	City	State
		Zip Code

HISTORY

Is there anything in this athlete's past medical history that would cause you to recommend that the athlete not be licensed in California? Yes No (Circle One)

Please explain: _____

NEUROLOGICAL EXAMINATION

CRANIAL NERVES (1 – 5)

1. Pupillary size in MM OD _____ OS _____ Reactivity OD _____ OS _____
 Note any asymmetry _____ N/A _____ (1)
2. Fundus OD _____ OS _____ N/A _____ (2)
3. Eye closure _____ N/A _____ (3)
4. Extraocular motility visual pursuit _____ saccades _____ nystagmus _____
 Describe any abnormality _____ N/A _____ (4)
5. Palate elevation _____ N/A _____ (5)

MOTOR (6 – 9)

6. Strength RUE _____ LUE _____ FILE _____ LLE _____ (0 – 5/5)
 List any abnormality _____ N/A _____ (6)
7. Tone RUE _____ LUE _____ FILE _____ LLE _____
 (I = increased D = decreased N = normal) N/A _____ (7)
8. Range of motion RUE _____ LUE _____ FILE _____ LLE _____
 Describe reason for restriction _____ N/A _____ (8)
9. Abnormal movements (tics, chorea, choreiform, myoclonus, etc.) _____
 Fasciculations _____
 Describe any abnormal movements _____ N/A _____ (9)

CEREBELLAR (10 – 15)

10. Finger – nose – finger Describe any abnormalities _____ N/A _____ (10)
11. Heel – shin Describe any abnormalities _____
 Abnormal = 3 failures N/A _____ (11)
12. Rebound check Describe any abnormalities _____
 Abnormal = 2 failures N/A _____ (12)
13. Rapid alternating hand movements
 Describe any abnormalities _____ N/A _____ (13)
14. One foot hop (3 trails, 5 secs ea ft)
 Describe any abnormalities _____ N/A _____ (14)
15. Romberg Describe any abnormalities _____ N/A _____ (15)

Athlete's Name: _____

GAIT (16)

16. Gait

Routine Gait _____ Heal Walk _____ Toe Walk _____ Tandem Walk _____

Note any abnormal movements, including upper extremity (ie: dystonic posturing, athetosis)

N/A _____(16)

SENSATION (17)

17. Sensation _____

N/A _____(17)

DEEP TENDON REFLEXES (18 – 19)

18. Deep Tendon Reflexes _____

N/A _____(18)

19. Babinski _____

N/A _____(19)

OTHER OBSERVATIONS (20)

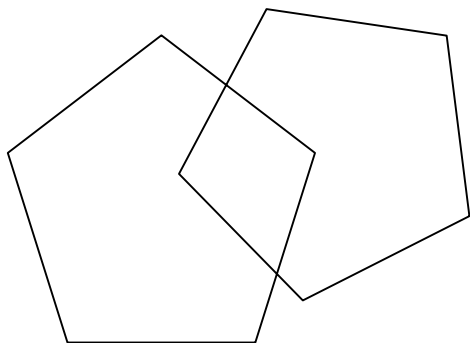
20. List any other symptoms or evidence of neurological abnormalities from history or observations.

N/A _____(20)

MENTAL STATUS EXAMINATION

MINI-MENTAL STATUS EXAM (1 - 9)

	Maximum Score	Score
1. What is the (year) (season) (date) (month)	5	_____
2. Where are we (state) (county) (city) (hospital) (floor)	5	_____
3. Name 3 objects: (e.g., cow, apple, bus) – one second to say each Then ask applicant all three after you have said them. (One point for each correct answer.) Then repeat them until he/she learns all 3. Count trials and record. Trials = _____	3	_____
4. Serial 7's. (One point for each correct.) Stop after 5 attempts	5	_____
5. Ask for the 3 objects repeated above (one point for each correct)	3	_____
6. Name a pencil and a watch	2	_____
7. Repeat: "NO IFS, ANDS, OR BUTS"	1	_____
8. Follow a 3-stage command: 'TAKE A PAPER IN YOUR RIGHT HAND. FOLD IT IN HALF, AND PUT IT ON THE FLOOR"	3	_____
9. Copy Design	1	_____



TOTAL SCORE
(0-21 suggests cognitive impairment)

N/A _____(1-9)

Athlete's Name: _____

EXAMINING NEUROLOGIST OR NEUROSURGEON

- ☐ As a licensed physician specializing in neurology or neurosurgery (circle one), I believe that this applicant could be permitted to be licensed in California.
- ☐ As a licensed physician specializing in neurology or neurosurgery (circle one), I *DO NOT* believe that this applicant could be permitted to be licensed in California.

Is further referral necessary? _____

Are additional exams needed? _____

I certify under penalty of perjury under the laws of the State of California that I am a licensed physician and that I specialize in neurology or neurosurgery.

Licensed Neurosurgeon or Neurologist's Name *(Please Print)*

Medical License Number

Signature of Neurosurgeon or Neurologist

Date

(Street Address) City State Zip () Phone #

The athlete is required to sign the attached authorization and acknowledgement form in either English or Spanish.

APPLICANT:

Please cooperate with the California State Athletic Commission to the fullest extent possible in making any medical history available.

The California State Athletic Commission is a public health authority, as defined in 45 CFR 164.501, exempt from HIPAA, and is authorized by Business and Professions Code Section 18600, et seq to collect information about the applicant's physical condition.

I AUTHORIZE the California State Athletic Commission under subdivision (b) of Section 1798.24 of the Civil Code to RELEASE any medical information or other personal information with respect to my status and licensure as a professional athlete which may be contained in any of its records to law enforcement agencies, physicians, or Athletic Commissions of other jurisdictions which have a need to know the information requested as determined by the commission.

Printed Name of Athlete

Date

Signature of Athlete

NEUROLOGICAL EXAMINATION ACKNOWLEDGEMENT

This examination is required for licensure and renewal of licensure of every professional athlete in the State of California.

I understand:

1. That the purpose of this screening examination is to detect possible early neurological changes resulting from cumulative head trauma which occur over extended periods of time and also changes that may affect my ability to engage in a professional boxing and/or martial arts match. This examination may uncover neurological findings that might hinder my ability to defend myself in a professional boxing and/or martial arts match.
2. That this examination does not predict possible future changes such as dementia, language difficulties, and problems with movement and coordination. Nor does it rule out the possibility of acute head trauma, such as subdural hematoma.
3. That this examination does not take the place of the general physical examination or diagnosis or medical treatment necessary for my general health or for any physical or mental condition I may otherwise have.
4. That the physician who is conducting this examination is not my personal physician and is not providing medical services to me.
5. That the results of this examination will be forwarded to the California State Athletic Commission for those purposes.
6. That any additional examinations, diagnostic procedures or treatment, including those which may be necessary for licensure as determined by the commission for the diagnosis and treatment of any physical or mental condition I may have, will only be done at my request and at my expense.

I have read and understand the statements made above.

Signature of Athlete

Date

Attention: Applicant

When completed, please mail ALL license application requirements to:

California State Athletic Commission
1424 Howe Avenue, Suite 33
Sacramento, CA 95825

Authority to provide the Athletic Commission with information requested on this examination is established pursuant to Section 18640, 18642, 18643, 18660, and 18711 of the California Business and Professions Code. All information is mandatory for licensure. Failure to provide this mandatory information will result in denial of a license.

Office Use

Approved By: _____

Date: _____



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MRI REVIEW SUMMARY

The MRI scan is to be performed on a 1.5 Tesla MR Machine with capabilities including fast spin echo and FLAIR imaging. Image sequences should include axial T1, T2, and FLAIR images; coronal images should be performed as a T2 coronal; and a single sagittal T1 sequence.

NAME OF ATHLETE (Print Name) _____

ATHLETE DATE OF BIRTH _____ DATE OF THIS REPORT _____

MRI REPORT IS WITHIN NORMAL LIMITS YES _____ NO _____

If NO, please explain:

ACCORDING TO THE CRITERIA ESTABLISHED BY THE CALIFORNIA STATE ATHLETIC COMMISSION (CSAC), WITH RESPECT TO THE ATHLETE'S NEUROLOGICAL CONDITION AND THE MRI (BRAIN IMAGING SCAN), IS THIS ATHLETE ELIGIBLE TO BE LICENSED TO COMPETE?

YES _____ NO _____

If NO, please explain:

Is Further Referral Necessary? YES _____ NO _____

If YES, please explain:

Are Additional Exams Needed? YES _____ NO _____

If YES, please identify the examination(s) and explain why they are needed to include your specific instructions.

This examination does not take the place of any other examination required by the CSAC. It also does not take the place of any general physical examination, diagnosis, or medical treatment of the applicant. It is solely for the purpose of aiding the CSAC in determining whether the applicant is neurologically fit to be licensed for competition.

Signature of Neurologist/Neurosurgeon

Date

Please print:

Name of Examining Neurologist/Neurosurgeon

State/License Number

Street Address

Telephone Number

City

State

Zip Code

Office Use

Approved By: _____

Date: _____